Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Anti-infectives: Oral Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Prior authorization is required for Adoxa, clindamycin 300 mg capsule, ciprofloxacin extended-release, Flagyl ER, Keflex 750 mg, metronidazole 375 mg, Monodox 75 mg, Oracea 40 mg, Solodyn, Zyvox tablet, and Zyvox suspension. Additional information about oral anti-infectives can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Drug Requested:

- ☐ Adoxa (all strengths)
- ☐ clindamycin 300 mg capsule
- ☐ ciprofloxacin extended-release tablet
- ☐ Flagyl ER 750 mg tablet
- ☐ Keflex 750 mg capsule
- ☐ metronidazole 375 mg capsule
- ☐ Monodox 75 mg capsule
- ☐ Oracea 40 mg capsule
- ☐ Solodyn (all strengths)
- ☐ Zyvox 600 mg tablet
- ☐ Zyvox 100 mg/5 ml suspension

Dose, frequency, and duration of requested drug:

Indication:

Has member tried other antibiotics to treat this condition? ☐ Yes ☐ No

If yes, please provide the drug name, dose, frequency, and result of therapy.

If no, please provide explanation.

ciprofloxacin XR requests: Please provide the medical necessity for requiring the extended-release (XR) dosage form over the immediate release 250 mg, 500 mg, or 750 mg.

clindamycin 300 mg requests:

Please provide documentation of the medical necessity for requiring the 300 mg capsule over the 150 mg capsule.

Keflex 750 mg, Flagyl ER 750 mg or metronidazole 375 mg requests:

Please document the medical necessity for requiring requested strength over the 250 mg and/or 500 mg strengths.

Monodox, Adoxa, Oracea, or Solodyn requests:

Please document the medical necessity for the branded formulation over available generic strengths/formulations

Zyvox tablet or suspension requests:

Was the culture positive for Vancomycin-Resistant Enterococcus? ☐ ☐ Yes ☐ No

Was the culture positive for MRSA? ☐ ☐ Yes ☐ No

Is the infection resistant or unresponsive to sulfamethoxazole/TMP? ☐ ☐ Yes ☐ No

Is the infection resistant or unresponsive to clindamycin? ☐ ☐ Yes ☐ No

Is the infection resistant or unresponsive to doxycycline or minocycline? ☐ ☐ Yes ☐ No

Please provide any additional clinical information

Pharmacy information

Name	Pharmacy provider no. *Optional*	Telephone no. ( )	Fax no. ( ) *Optional*
Address		City	State / Zip *Optional*

Prescriber information

Last name / First name / MI			MassHealth provider no.	DEA no.
Address			City	State / Zip
E-mail address *Optional*			Telephone no. ( )	Fax no. ( )

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date